



CITY OF GLOUCESTER

Health Department
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Public Health
Prevent. Promote. Protect.

FOOD ESTABLISHMENT PERMIT APPLICATION

Application must be submitted at least 30 days before the planned opening date or 30 days before expiration of license

**** ANY PAYMENTS RECEIVED AFTER FEBRUARY 1ST WILL BE SUBJECT TO A \$50 LATE FEE ****

THERE IS A FEE FOR EACH PERMIT. Please check all that applies:

_____ \$125-RETAIL _____ \$200-FOOD SERVICE ESTABLISHMENT _____ \$75-RESIDENTIAL _____ \$100-CATERING

Length of permit (check one): _____ ANNUAL _____ SEASONAL/from _____ to _____

Establishment Name: _____ Contact Person: _____

Establishment Address: _____

Establishment Mailing Address (if different): _____

Establishment Telephone No: _____ 24 Hour Emergency No: _____

Establishment Owned By:

An association _____ A Corporation _____ An Individual _____ A Partnership _____ Other Legal Entity _____

Owner's Email Address (or person in charge): _____

If a corporation or partnership, give name, title, and home address of officers or partner:

Name: _____ Title: _____

Home Address: _____
(STREET) (CITY) (STATE) (ZIP CODE)

Person Directly Responsible For Daily Operations (Owner, Person in Charge, Supervisor, Manager, etc.):

Name & Title: _____

Address: _____
(STREET) (CITY) (STATE) (ZIP CODE)

Telephone No: _____ Fax: _____ Emergency Telephone No: _____

District or Regional Supervisor (if applicable):

Name & Title: _____

Address: _____
(STREET) (CITY) (STATE) (ZIP CODE)

Telephone No: _____ Fax: _____ Emergency Telephone No: _____

PLEASE CIRCLE EITHER YES OR NO: City Water: yes/no Well: yes/no Septic System: yes / no
Days & Hours of Operation:_____ No. Of Employees:_____

NAME OF PERSON IN CHARGE CERTIFIED IN FOOD PROTECTION MANAGEMENT (Food Service Establishment ONLY)
Please attach copy of certificate:

Name:_____ Phone No:_____ Certification No:_____

Person trained in Anti-Choking Procedures (if 25 seats or more): YES:_____ NO:_____

Establishment Type (check all that apply):

<input type="checkbox"/> Retail (_____ Sq. Ft.)	<input type="checkbox"/> Food Delivery
<input type="checkbox"/> Food Service- (_____ Seats)	<input type="checkbox"/> Residential Kitchen for Retail Sale
<input type="checkbox"/> Food Service- Takeout	<input type="checkbox"/> Residential Kitchen for Bed & Breakfast Home
<input type="checkbox"/> Food Service-Institution (_____ Meals/Day)	<input type="checkbox"/> Residential Kitchen for Bed & Breakfast Establishment
<input type="checkbox"/> Caterer	<input type="checkbox"/> Frozen Dessert Manufacturer

Food Operations (check all that apply):

Definitions: PHF - potentially hazardous foods (time/temperature controls required)
Non-PHF - non-potentially hazardous foods (no time/temperature controls required)
RTE - ready-to-eat foods (Ex. Sandwiches, salads, muffins which need no further processing)

☐ Sale of Commercially Pre-Packaged Non-PHF
☐ Sale of Commercially Pre-Packaged PHF
☐ Delivery of Packaged PHF
☐ Reheating of Commercially Processed Foods For Service Within 4 Hours
☐ Customer Self-Service of Non-PHF and Non-Perishable Foods Only
☐ Preparation of Non-PHF
☐ PHF Cooked to Order
☐ Preparation of PHF for Hot and Cold Holding for Single Meal Service
☐ Sale of Raw Animal Foods Intended to be Prepared by Consumer
☐ Customer Self-Service
☐ Ice Manufactured & Packaged for Retail Sale
☐ Juice Manufactured & Packaged for Retail Sale
☐ Offers RTE PHF in Bulk Quantities
☐ Retail Sale of Salvaged Out-of-Date or Reconditioned Food
☐ Hot PHF Cooked and Cooled or Hot Held for More Than a Single Meal Service
☐ PHF and RTE Foods Prepared for a Highly Susceptible Population or Facility
☐ Vacuum Packaging/Cook Chill
☐ Use of Process Requiring A Variance And/Or HACCP Plan (including bare hand contact alternative, time as a public health control)
☐ Offers Raw or Undercooked Food of Animal Origin
☐ Prepares Food/Single Meals for Catered Events or Institutional Food Service
☐ Other(Describe):_____

I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that the food establishment operation will comply with 105 CMR 590.000 and all other applicable laws. I further certify that my water, sewer and tax bills have been paid to the City of Gloucester.

Signature of Applicant:_____ Date:_____

Social Security Number or Federal ID:_____ Signature of Individual or Corporate Name:_____

*****HEALTH DEPARTMENT USE ONLY*****

Date Received

Date Inspected

Approved By

Permit # Issued